Participation in Shareholding Networks for the Care of Older People in Rural, Thailand

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ABSTRACT

Given the lack of knowledge about rural-dwelling older adults' experiences with health-promoting activities in shareholding network. The purpose of the study reported here was to explore older adults' experiences with health promotion in shareholding network for the care of older people living in rural areas. Qualitative research methodology were used in-depth interviews and conducted with 15 older members of shareholding network in Thailand during 2017, and interview transcripts were subjected to content analysis guided by the World Health Organization's theoretical framework for health promotion. Among the results, knowledge, fellowship and dignity were identified as general elements of health-promoting experiences, and activities organised by the shareholding network reflected the four categories of health-promoting elements proposed by the World Health Organization: empowerment to control health, participation in society, self-determination and shared responsibility. The results indicate that activities in the shareholding network contributed to the support provided by peer volunteers, which has potential to be an effective strategy for increasing activity among older adults, particularly ones who are inactive and socially disengaged. Conclusion, shareholding network for the care of rural-living older people seem to promote a culture of volunteerism that holistically satisfies individual older person's needs in the process of strengthening his or her self-care.

Keywords:

Older adults, Health promotion, Shareholding network for the care

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Introduction

Amid the ageing of Thai society, Thailand's population of older adults has expanded (Institute for Population & Social Research, 2020), as have their demands for healthcare. Such trends have arisen despite overall healthier ageing in Thailand and the growth of health-promoting activities tailored for older people, the latter of which have become increasingly important in Thai society. However, as health promotion for older adults has been addressed in Thailand, it has become clear that rural-dwelling older adults in the population have worse health than their counterparts in urban communities (Knodel, Teerawichitchainan, Prachuabmoh, & Pothisiri, 2015). The situation is made worse by the migration of the working-age population from rural to urban areas as people seek opportunities for employment in cities (Knodel, Prachuabmoh, & Chayovan, 2013). Consequently, older people living in rural areas often lack the necessary family support that they would have enjoyed in days gone by (Action with Communities in Rural England, 2014). Recently, shareholding networks for healthcare in Thailand's communities have provided access to important resources and organised health-promoting activities for older adults in rural areas. In general, shareholding networks for the healthcare of older people aim to promote equal opportunities for all older adults by respecting diversity, advocating human dignity, responsibility, increasing access to high-quality healthcare services for older people and supporting the work of all organisations involved in healthy ageing (Voraroon, Enmarker, Meebunmak, & Hellzen, 2017a & 2017b).

However, all such networks require the cooperation of older people, their families, health professionals, consumers, local administrative organisations, public health centres and so-called "ageing clubs" with members on public communities. In rural areas, people involved in ageing clubs and groups have had diverse experiences with healthcare and share interests in developing and managing healthcare policy and healthcare services (Voraroon, Hellzen, Enmarker, Meebunmak, & Devik, 2019). Thus, the creation of shareholding networks for care in rural areas can serve as a valuable way to address social determinants of health in care among targeted elderly populations as well as follow the guidelines for promoting the health of older adults (World Health Organization, 1984).

Theoretical of Health Promotion Framework

The concept of health promotion is positive, dynamic and empowering, which makes it rhetorically useful and politically attractive. By considering the concept as such, researchers have planned spiritual, educational, political, economic and organisational initiatives for actions aimed at improving the health of individuals, groups and communities (World Health Organization, 1986). In particular, health promotion should facilitate people in enhancing their control over their personal health by integrating basic elements of health-promoting interventions - namely, empowerment, participation in society, self-determination and shared responsibility (World Health Organization, 1986; World Health Organization, 2013; World Health Organization, 2002a; World Health Organization, 2002b). *Empowerment;* The heart of that process is the empowerment of individuals, groups and communities, who possess and control their own actions and destinies (World Health Organization, 1986). For older adults, empowerment by way of health promotion is a resource for enabling engagement in community networks of care. That process authorises people to enhance their self-care and share responsibility with sources of social support as they develop flexible healthcare systems that strengthen the participation of the entire community. As Poomsanguan (2014) has described it, empowerment via health promotion is a process of enhancing the ability and capacity of individuals, families and communities to control factors that influence their health, particularly by taking advantage of available resources and engaging in activities in order to maintain physical and mental health. Ultimately, empowerment can prompt real-world discoveries when coupled with procedures and practices tailored to the individual (Palasap, 2017). *Participation in society;* Health promotion should also involve the full participation of all community members in the development of their health (World Health Organization, 1986). In that context, *community participation* means the active involvement of all people in communities, including ones engaged in analysis, decision making, planning and programme implementation, among other activities (World Health Organization. (2002b). The social participation of older people facilitated by community or shareholding networks should also involve collaboration towards improving healthcare among all older adults in the community. Because participating in such networks can increase the quality of life of older people and facilitate their continued social participation, shareholding in the networks can fulfil the healthcare needs of the elderly. *Self-determination;* According to WHO (2000), health promotion additionally involves promoting self-determination with an emphasis on personal responsibility and motivation, especially in making decisions about personal health (World Health Organization, 2002a) all of which is important in combating low self-esteem (Woolhead, Calnan, Dieppe & Tadd, 2004). Regarding the relationship between health and decision making, Barenfeld et al., (2017) have pointed out that health-related decisions are made with reference to three distinct needs: maintaining health, learning more for oneself or teaching others and advocating for others (Barenfeld, E.,

Gustafsson, Wallin, & Dahlin-Ivanoff , 2017). To that, Sørensen et al., (2012) have added that responsible health-related decision making requires health literacy, which, developed in personal interactions with one's environment, entails the knowledge, motivation and competence to access, understand, appraise and apply health-related information (Sørensen, K., (Van Den Broucke, Fullam, Doyle, Pelikan, Slonska, Consortium, 2012). At the same time, self-determination is the process of making decisions to satisfy the health-related needs of not only oneself but others as well. *Responsibility;* Responsibility as strategic care also aims to reduce social inequality in the healthcare sector, including inequality experienced by older adults, which contributes significantly to the general inequality in healthcare provision (World Health Organization. (2002b). While health professionals have a major responsibility to act as advocates for health at all levels of society (World Health Organization, 2013) their participation in working with communities depends upon individuals' taking responsibility for their personal health first. To improve that dynamic, making health professionals at community organisations available to support and promote older people's wellbeing should support the positive reception of elderly people in communities with increased responsibility. At the same time, health promotion among older adults should involve maintaining teams of older people in communities to strengthen their peers' personal responsibility for their healthcare. As a result, older people can become able to initiate and perform health-promoting activities based on their own recommendations (Strümpel & Billings, 2006). Altogether, the basic elements of health-promoting interventions empowerment, participation in society, self-determination and shared responsibility (World Health Organization, 1986; 2002a; 2002b) enable older adults to increase control over the determinants of their health and maintain, if not improve, their health. Moreover, all of those elements can be activated in shareholding networks within communities, especially for older adults, which can be vital to supporting their health-promoting actions by way of self-empowerment (World Health Organization, 1998). Despite that potential, however, older adults have long been neglected as targets of health-promoting activities (Strümpel & Billings, 2006). However, as WHO experts have unanimously reiterated the importance of a healthy lifestyle at every stage of life, health-promoting measures targeting the elderly have begun to grow in number. Among them, many are based on evidence that exercising, avoiding smoking and alcohol consumption, participating in learning activities and integrating into one's community can inhibit the development of numerous diseases and the loss of functional capacity and, as a result, improve quality of life and lengthen life expectancy (Golinowska, Groot, Baji, & Pavlova, 2016; World Health Organization, 2015). Health promotion for the elderly lifestyle in rural should be focused and research. Because it will be too late for their life. Therefore, purpose of the study was to explore older adults' experiences with health promotion in shareholding network for the care of older people living in rural areas.

Methodology

This study used a qualitative study. Qualitative content analysis followed a deductive approach (Elo & Kyngäs, 2008). which is useful when research has already been conducted on a phenomenon (e.g. experiences with shareholding network). Based on our prior (Voraroon, Enmarker, Meebunmak, & Hellzen, 2017a; 2017b; Voraroon, Hellzen, Enmarker, Meebunmak, & Devik, 2019), we wanted to test participants' experiences against current theory about health promotion informed by WHO's framework and, in the process, assess WHO's conceptualisation of health (World Health Organization, 1984; 1998; 2002b, 2015) in relation to participants' experiences with shareholding network.

Setting and participants

The study was conducted in a rural community in central Thailand with a senior population (i.e., older than 60 years) of 1,171 people—that is, 59 older adults per km^2. From 2013 to 2017, the percentage of older people in the community's sub-district jumped from 15.42% to 22.39% (Suphanburi Province Public Health Office, 2007). The major occupation of the older population is agriculture, including planting rice and other crops and raising animals. Two primary government agencies provide local healthcare services; whereas the Local Administrative Organization provides basic healthcare services for older people in line with government policy prescribed by each ministry, the sub-district health-promoting hospital is responsible for health promotion, prevention, treatment, and recovery based on the criteria of the Ministry of Public Health. A purposive sample of 11 older women and four older men aged 62 - 80 years took part in the study, nine of whom lived alone and six of whom lived with their partner or children, all in the same rural area. All participants currently received activities of a healthcare-related shareholding network and were all active to a different degree in shareholding network activities. Characteristics of the participants appear in Table 1.

Table 1 *Sample of participants in a Thai shareholding network for older people*

Interviewee	Gender	Age (in years)	Marital status	Residential status
Interviewee 1	Woman	72	Widowed	Alone
Interviewee 2	Woman	68	Widowed	Alone
Interviewee 3	Man	72	Married	With children
Interviewee 4	Man	71	Married	With spouse and children
Interviewee 5	Woman	70	Widowed	Alone
Interviewee 6	Woman	62	Married	With spouse and children
Interviewee 7	Woman	70	Unmarried	Alone
Interviewee 8	Woman	71	Married	With spouse and children
Interviewee 9	Woman	72	Unmarried	Alone
Interviewee 10	Woman	72	Unmarried	Alone
Interviewee 11	Man	80	Married	With spouse
Interviewee 12	Man	77	Married	With spouse
Interviewee 13	Woman	70	Widowed	Alone
Interviewee 14	Woman	75	Married	With spouse and children
Interviewee 15	Woman	63	Married	With spouse and children

Data Collection

The first author (SV) collected data during interviews from January to October 2017. The interviews took the form of dialogues between the participants and the researcher. Open-ended questions were asked to encourage participants to talk freely about their personal experiences with health-promoting activities in shareholding network for the care of rural-dwelling older people. During in-depth interviews, the participant and the researcher attempted to structure the former's various experiences recounted in stories. To that end, the primary question guiding conversations during interviews was, "Can you please tell me about your activities to improve your health, in your daily life, and how you experience that?" During those conversations, the researcher interrupted as seldom as possible and

commented only to better understand the stories and prompt participants to expand upon their feelings about their experiences and what those experiences have meant. Follow-up questions included, "What happened then?" "Can you please tell me more?" and "How did you feel?" The interviews took place in the participants' homes or in meeting rooms in the sub-district health-promoting hospital, depending on each participant's preference. The interviews lasted between 45 and 80 minutes, were performed in Thai and were digitally recorded and transcribed verbatim.

Data Analysis

Data from interview transcripts were analysed using deductive qualitative content analysis (Elo & Kyngäs, 2008). In the deductive phase, a structured categorisation matrix was developed with reference to WHO (1986) elements of health promotion for uses as a lens to guide the analysis of the transcripts. Analysis began with multiple readings of the transcripts to become familiar with the data and acquire an overview of the content (World Health Organization, 1986). Next, the transcripts were carefully reviewed for details in their content, and all text corresponding to the categorisation matrix was highlighted, coded and assigned to relevant categories in the matrix (Andersson, Sjöström-Strand, Willman, & Borglin, 2015a). That phase of analysis was completed with the purpose of the study firmly in focus, that is, to illuminate older adults' experiences with how they can pursue health-promoting activities in shareholding network and why (Andersson, Willman, Sjöström-Strand, & Borglin, 2015b). Throughout the process, the first researcher (SV) led analysis while the other researchers evaluated each part of coded text for its appropriateness in assigned categories in the matrix.

Trustworthiness

To promote the credibility of the study's results, the close, long-term engagement of the researchers with the participants afforded the possibility of collecting accurate data. Moreover, to diversify the data, a variety of participants were purposively sampled. Following analysis, the findings were shared with experts who have experience from older people research to ensure their feasibility and dependability. To ensure confirmability, participants' interviews were recorded in full and without bias. Last, as an external check data were controlled by independent researchers at research seminars.

Ethical Considerations

The study followed the ethical principles of the Declaration of Helsinki (World Medical Association; 2013). All participants were informed about the study and assured that their participation was voluntary and that they could withdraw at any time. All participants gave their written informed consent and were guaranteed confidentiality and anonymity in the presentation of findings. The research was approved by Thailand's Ethical Review Committee for Research with Human Subjects (IRB: SP 0032.002/4/3.4/2018).

Discussions and Conclusion

Via deductive content analysis, we identified the four components of health promotion defined by WHO, along with 10 subsequent subcategories that afforded insights into various aspects and nuances of participants' experiences with health promotion in shareholding network. Table 2 lists the categories and subcategories. During interviews, participants indicated that they both received care from and supported other members in shareholding network in activities involving home care, grocery shopping, social and emotional support, help and motivation with physical activities, education about health and health-promoting activities and exchanging information between themselves and public healthcare services. While engaging in those activities, participants often experienced control by playing the role of network members. Explaining their fear of losing ability and emphasising the significance of maintaining

autonomy, participants reported valuing their relationships with members of shareholding network because the network made them feel less restricted, more dignified and more in control of their daily lives.

Table 2 Overview of categories and subcategories.

Categories	Subcategories
Empowerment to control health	Building competencies about healthier lifestyles
	Cultivating self-respect
	Being a resource for others
Participation in society	Doing meaningful work
	Pursuing traditional wisdom
	Improving the community
Self-determination	Taking control
	Advocating for others
Shared responsibility	Caring about oneself and others
	Feeling interdependent

Empowerment to Control Health

Participants described that being a member of a shareholding network increased their knowledge about factors that influence their health and strengthen their ability to take advantage of available resources. The analysis revealed that empowerment to control health was reflected in three subcategories: building competencies about healthier lifestyles, cultivating self-respect and being a resource for others.

Building competencies about healthier lifestyles

Information about health and how personal activities could help to maintain, if not improve, both physical and mental health were highly valued among participants. For some, such information was entirely new, and it seemed especially important that it was delivered by someone whom they trusted. One participant explained:

> *"They [members from the network] invited me to join, and they shared their experiences. Before, I didn't know how to take care of myself or others, but my friends encouraged me until I understood. Now, I see the benefits, and I'm not so concerned by the barriers anymore. I'm old, but I'm still a strong, competent person. I don't have to depend on others. All activities in the network are beneficial to my health, and I feel less lonely". (P9)*

Another participant described how she used that knowledge in her daily activities:

> *"The healthcare knowledge is useful in my daily life. For example, I eat nutritious food for older people, take medications on time, exercise with my friends in the dance group and treat my skin with Thai herbs. … It's not hard to do, if you have faith in it". (P13)*

Cultivating self-respect

Empowerment also emerged in heightened personal ability despite physical limitations due to ageing or disease. Along with the support received from fellow members of shareholding network, feelings of self-respect represented a major motivation for participants to engage in health-promoting activities. Feelings of self-confidence and pride surfaced often as they spoke during interviews:

"In the past, my blood sugar was too high. I liked to consume candy, mangos and sweet soft drinks. I had symptoms of diabetic retinopathy disease … and I felt that my health was really bad. That was my reason for joining the network. Health volunteers visited me and warned me about my risky behaviours. … Now, I'm feeling better, and I've started to help other people in the same situation. I'm proud of what I've done, and I feel important". (P2)

Another participant also described feelings of wellbeing that accompanied increased self-esteem:

"In fact, everything has to start with me and my self. Participating in the network gave me the opportunity to engage in beneficial activities, and I can choose activities that suit me. Although I'm old, I think that I can do anything! So, I can support and encourage others to do the same as me". (P4)

Being a resource for others

The value of being a resource for others was highlighted by all participants and seemed essential to their wellbeing and development of empowerment. Some participants provided examples of having helped to mobilise their peers from sitting in wheelchairs to being able to walk or even attend dance activities. In other cases, participants had visited peers to observe their living conditions and eventually mediated contact with related agencies in the community on their behalf, while others had made social visits to provide and exchange information. Such activities made the participants aware of their internal resources. One participant said:

"We [members in the network] can do this, and we can help them [older people]! It's positive thinking. We should have a fight with our minds. I'm retired. I have time, knowledge and channels. ... I do healthy activities such as eating healthy food, exercising, controlling my emotions with [Buddhist] meditation … and I visit older people who lack those opportunities. … It's a really good feeling ... I'm a useful senior person". (P2)

Participation in Society

The interviews revealed that being a member in the shareholding network facilitated participation in their communities in several ways. Three dimensions of participation in society were identified in the subcategories of doing meaningful work, pursuing traditional wisdom and improving the community.

Doing meaningful work

Involving either the provision or reception of care, the activities in the shareholding network were experienced as meaningful and indicative of solidarity by participants. Some participants who functioned primarily as care providers referred to the activities as "jobs" without pay:

"I got involved in healthcare for older adults with an open mind, wanting to help and care for other older adults in the community without hoping for payment. My reason [for joining] is to get involved in activities that are beneficial for older adults in our community so that their health can be improved. My participation will also help me to be healthy". (P6)

The significance of the activities also related to feelings of group membership. Participants recounted their visits to homebound older adults in their communities, accompanied by representatives of the sub-district health-promoting hospital and sub-district municipality. They emphasised the importance of informing and explaining to friends the importance and benefits of networking. As one participant put it, "It's a feeling that stems from the cooperation of the groups of elderly people living together in this

community" (P3). Feelings of solidarity also emerged regardless of whether the participants were providers or recipients of care. Another participant stated:

> *"The network team encourages and motivates me. I have many diseases and used to sit in a wheelchair. I tried to get up and walk and dance with others. … I didn't feel abandoned at all. Now, I have my capacity to do things and work together with the team. Because I need to return the best things to others in my community, just as I've received the best things from them". (P6)*

Pursuing traditional wisdom

Participating in the network was also viewed as useful to transfer traditional knowledge about healthy behaviours (e.g. traditional dances and meditation) and non-medical treatments (e.g. with herbs and health foods). In that way, participation in the network allowed the survival of traditional culture, the transfer of knowledge between generations and, in turn, the improved health of individuals. One participant explained:

> *"I got knowledge [about traditional treatments] from other members in the network. Using Thai herbs for treating illnesses is a traditional way to stay healthy. The use of herbal medicine has been based on empirical treatment and passed on from generation to generation. I agree that herbs are very useful, so I decided to use herbs in my daily routines, like in herbal shampoo, herbal soap, herbal moisturiser cream and herbal balm to release muscle pain. Many types of herbs can be found in my area … and herbs are very cheap". (P1)*

By allowing them to counter isolation and gain a sense of belonging, participating in the network was vital to participants. Opportunities to reminisce or share time with old friends and past acquaintances - peers who had been and still were important in the participants' lives further - contributed to the meaningfulness of experiences in their daily lives.

Improving the community

Participants seemed deeply motivated to contribute to improving the lives of older adults in their area. They recognised that mobilising volunteers was necessary to promoting health as well as a means to overcome shortages in public healthcare. As one participant put it:

> *"I help to care for older people in the community a lot. I have a role as a volunteer who cares for the community's older people, and I've received training organised by the Ministry of Public Health. I take part in the network to achieve the desired objectives for older people's care. I want to help and encourage abandoned people…" (P5)*

Activities in the network were also viewed as important to reducing potential burden on family caregivers. One participant stated:

> *"The fact that I've become able to care for myself means that I don't have to depend on my family. I can participate in most activities in the community. I can rely on myself without becoming a burden to others". (P8)*

Bringing happiness into the community was another common theme in the interviews:

> *"Honestly, my participation in the community healthcare for the elderly network brings me happiness. … I'm proud of what I'm doing. It makes me glad to see that the elderly living in the community are happier". (P9)*

Self-Determination

Being able to make decisions and influence their personal circumstances meant a great deal to

participants. Membership in the shareholding network allowed participants to take control of their daily habits and expand their capacity to make informed decisions instead of simply following instructions. Self-determination achieved via the network was reflected in two subcategories: taking control and advocating for others.

Taking control

During interviews, participants provided many examples of how participating in the shareholding network had changed their destinies and situations in life. Some reported past experiences of heavy alcohol consumption, low physical activity and feelings of disappointment. In such cases, becoming part of the network marked a turning point towards encouragement and optimism. Participants were determined to improve their health by themselves and expressed immense satisfaction about managing to fulfil aspects of their personal plans of care. One of them said:

> *"I always go to see the doctor at the hospital for screening, and I participate in the community activities with the older persons' network a lot. I come every time because I think it's good for me". (P11)*

Another participant added,

"I participate in many projects based on my own decisions. ... I decide how I manage my time in the network" (P3).

Advocating for others

Self-determination also surfaced as an element in participants' willingness to care for other members in the network and older adults in the community. Although they used words such as "responsibility" and "duty" when explaining their activities to help others, they seemed proud and pleased with their performance. The feeling of being a volunteer persisted even when their work appeared to be highly organised within the network. Each network member seemed equally important, and resources as well as challenges were shared. One participant explained:

> *"... I recognise the benefits [of the network] for every older person in our community, and I view relationships and cooperation for older adults as the most important. I'm a person in the community, and it's a duty and responsibility as a member of the community [to participate in the network], so I decided by myself to participate in the network. I was able to join and share ideas in the positive health policy activities. If my network team discovers a problem, then we [the network] can help to look for solutions by emphasising the sharing of ideas and looking for guidelines to manage health problems together. We can design the best health policy for ourselves. Don't forget that the important thing is to help older adults in the community to have good health". (P12)*

Shared Responsibility

Analysis revealed that participating in the shareholding network implied increased feelings of personal responsibility for not only one's health but also the health of others. However, such responsibility seemed neither demanding nor imposed; on the contrary, it was regarded as self-evident and part of a shared mission between themselves and the Thai government. The idea of shared responsibility emerged in two categories: caring about oneself and others and feeling interdependent.

Caring about oneself and others

Increased attention to disease prevention and an improved capacity to practise self-care were evident outcomes of being a member of the shareholding network. Participants often referred to their personal responsibility to lead good lives and stay healthy, as well as about experiences

with asking for help from other members of the network. Although most of their stories were about providing help to others, reciprocity was an important aspect of activities-based relationships. One of the participants said:

> *"I help with self-care. It's my duty! It's a duty for every member to cooperate. I help by representing friends who can't come to participate. It's also very good to get to share my self-care experience and knowledge with other older adults". (P8)*

Several comments from participants indicated the dynamics of their situations: that sometimes they needed help, whereas at other times they could provide help. The flexibility of those situations was a source of hope and strengthened participants' feelings of doing one's part:

> *"The people in the community make me feel important and support me, by giving me the motivation to try to walk. … I can improve my health status by myself, and I don't depend on care from others. Now, I have the capacity to do things and work together with the network team". (P6)*

Feeling interdependent

Cooperation between healthcare personnel, various public partners and participants was highlighted as a cornerstone of the shareholding network. Feelings of being on the same team and working to achieve the same goal were often communicated during interviews:

> *"It's a duty and responsibility as a member in the community to care for elderly people in the area. There's no need to complicate things with lots of procedures, because we [the network] and government officials are already on the same team and have a strong work history". (P10)*

Most participants valued membership in the network as a means to curb their loneliness and isolation and, in turn, tended to highlight the social benefits of membership more than the individual ones. They spoke about achieving a sense of belonging, of being a member of a club and of wanting to contribute to society. Implicitly, such fellowship afforded by the network could also operate as a safety net for their own good. In that sense, membership provided access to a support system that could be used in the future as necessary.

Discussion

The purpose of the study was to examine older adults' experiences with health promotion in shareholding network for the care of older people living in rural areas. With reference to their experiences, the analysis identified the four elements of health promotion proposed by WHO (1986, 2000, 2002, 2013), which held shared meaning for participants in their specific context. Although the four categories are discussed separately in what follows, their contents overlap, and the elements of knowledge, fellowship and dignity were commonly identified within the experiences of participants.

Empowerment to Control Health

Participants described that being a member in a shareholding network increased their knowledge about factors that influence their health and strengthen their abilities to take advantage of available resources. Empowerment has been described as essential to the intention to increase a person's power in order to help him or her to gain control over personal health (Berg, Sarvimäki, & Hedelin, 2006). In our study, a central aspect of becoming empowered was interaction with others. According to Leyshon (2002) and Fotoukian, Shahboulaghi, Khoshknab, & Mohammadi (2014), for example, active participation is essential in the empowerment process, which can generate outcomes of liberation, emancipation, energy and power sharing. Participants reported sharing knowledge and gaining power by perceiving such knowledge as useful, either for care providers or care

recipients. Their competencies increased due to access to concrete information about healthy lifestyles, and their participation in the network also afforded them resources for self-care and feelings of being in greater control over their lives. Accordingly, empowerment while participating in shareholding network can be conceived both as a process and an outcome, both of which can highlight organisational components of empowerment that are poorly understood (Lindacher, Curbach, Warrelmann, Brandstetter, & Loss, 2018). According to Dowling, Murphy, Cooney, & Casey (2011) engaging in the empowerment process requires self-awareness, which in our study was demonstrated by participants' engagement in self-care supported by interactions with other members of the network. A consequence of increased self-awareness and self-capacity despite physical limitations due to ageing and disease-related complications was heightened motivation to improve personal health (Tengland, 2007). In that sense, the health of network members could be maintained, if not improved, by affording them independence and autonomy with the acknowledgement that care provision is part of the empowerment process (Faulkner, 2001).

Participation in Society

Craig (2004) has stressed that, for older adults, citizenship and community-oriented goals closely relate to independence, social participation and identity. In our study, participants revealed that being a member in the network facilitated their participation in their communities in several ways, which promoted their efforts to achieve the mentioned goals. In Nordic countries, by comparison, respect for older people's right to autonomy and participation is emphasised in healthcare and social policy frameworks. The importance of participating in shareholding network, older adults' satisfaction with their participation and simply having the choice to participate could shed additional light on aspects of what being part of a community means to older adults. That possibility aligns with WHO's (2002) conceptualisation of active participation as supporting older people's health, independence and life satisfaction in an active ageing "process of optimising opportunities for physical, social and mental wellbeing throughout the life course, in order to extend healthy life expectancy, productivity and quality of life in older age". In Scandinavia and other Western countries, governments support telecare's purported potential to benefit the care of older people in rural areas and increase their participation and independence in everyday life (Stav, Hallenen, Lane, & Arbesman (2012). As shown in our study, the Thai government seems to have taken an alternative route by focusing on shareholding network activities as a way to prevent reduced interdependence and reliance on others as potential isolation-increasing activities. The significance of feelings of being part of a group were emphasised by participants, as was the importance of supporting fellow network members and even lobbying in the community about the importance and benefits of networking. As Cattan, White, Bond, & Learmouth (2005) have suggested, efforts in health promotion geared towards encouraging engagement in one's community are more successful when they have been developed with the input of members of the targeted population. Such thinking falls in line with Sandman (2004), who posits that the concept of autonomy comprises four aspects, self-determination, freedom, independence and having one's desires fulfilled, all of which are compatible with the concepts of competence, self-respect and community.

Self-Determination

Being able to make decisions and influence their circumstances meant a great deal to participants. Membership in the shareholding network allowed them to exercise control over their daily habits and expanded their capacity to make informed decisions, not simply follow instructions. As such, experiences with the network seem to have afforded effective strategies for promoting self-reported health, subjective wellbeing and quality of life. As indicated during

interviews, participants felt that participating in the network had changed their situations in life. For older adults who are cognitively competent but depend upon help in order to live autonomously, it is important that *self-determination* is defined as opportunities to decide for oneself what is important to one's self-respect (Raymundo, Goldim, 2008). Respect for autonomy is an important element in the care of older adults (Hellström, & Sarvimäki, 2007) that can enhance self-determination and quality of life (Välimäki & et al., 2004). Associated with autonomy, self-determination is an important indicator of quality of life and positively correlated with activity, mental agility, social wellbeing, self-image and health, whereas lack of self-determination is linked to depression and hopelessness (Hammar, Berglund, Dahlin-Ivanoff, Faronbi, & Gustafsson, 2008). In our study, self-determination also manifested in participants' willingness to care for other members in the shareholding network. Together with self-determination, competence and community contributed to participants' capacity to effectively manage activities in which they participated and, when satisfied, can significantly contribute to improved self-reported health (Arnold, Bourdeau, & Nagele, 2005).

Shared Responsibility

Analysis revealed that participating in the shareholding network increased feelings of personal responsibility for one's health as well as the health of others. Participants often referred to their personal responsibility to lead good lives and stay healthy, as well as their experiences with seeking help from fellow network members. WHO (2002) suggests that active ageing enables older adults to continue to live meaningful lives by optimizing opportunities for physical, social and mental wellbeing throughout the life course, in order to extend healthy life expectancy, productivity and quality of life in older people. At the same time, shared responsibility is always a question of free will, common barriers to which are internal (Leino-Kilpi & et al., 2000). Among older people, the most common internal barriers to free will are immobility (Murphy, O'Callaghan, & Clare, 2007) and dependence upon others in everyday life (Scott, 2003). One way to promote the free will, self-respect and competence of older adults, as shown in our study, is volunteering. Indeed, during interviews, participants who were actively involved as peer volunteers in shareholding network activities gave insights into how older people can maintain their engagement in the community. As people age, they are at increasing risk of a downward spiral of reduced activity and less social engagement that can end in decreased physical capacity, compromised health and a growing sense of inactive participation as supporting older people's health, independence and life satisfaction in an active ageing decreased dignity (Shankar, McMunn, Demakakos, Hamer, & Steptoe, 2007). For older adults, maintaining dignity, by contrast, involves conceiving and respecting them for who they are and what care-related demands they have, both supported by an ambition to understand them as individuals [e.g. Chochinov, Hack, McClement, Kristjanson, & Harlos, 2002; Jacelon & Connelly, 2004; Lohne, Aasgaard, Caspari, Slettebø, & Nåden, 2010). Activities in shareholding network can help to disrupt that downward spiral of inactivity and disengagement. As our study indicates, such activities contribute to support from peer volunteers, which has the potential to contribute to effective strategies for increasing the activity of older adults, particularly ones who are inactive and socially disengaged. According to McMunn et al., (2009), volunteering also tends to be popular among older people even into their mid-70s (McMunn, Nazroo, Wahrendorf, Beeeze, & Zaninotto, 2009). Moreover, evidence corroborates the idea that volunteering contributes to social connectedness, mental wellbeing, quality of life, self-esteem, active lifestyles and delayed mortality (e.g. Cattan & et al., 2005; McMunn, Nazroo, Wahrendorf, Beeeze, & Zaninotto, 2009; Kim & Konrath, 2016; Parkinson, Gibson, Robinson, & Byles, 2010; Wahrendorf & Siegrist,

2010). Last, peer volunteers are positive role models who can support and empower older adults, and peer-led approaches have the potential to be cost-effective as well as sustainable (Allen, Rosas-Lee, Ortega, Hang, Pergament, & Pratt, 2016).

Conclusion

Although maintaining the dignity of older adults can prove challenging in caring for them, preserving dignity is an important component of their care as well as a crucial ethical aspect, an ethos, in caring for patients (Edlund, 2002; Von Post, & Eriksson, 2000) Among researchers who have recently examined dignity in relation to care, Gustafsson, Wigerblad, & Lindwall (2014) have shown that a patient's dignity is optimally assured when they are met in ways that demonstrate equality and that highlight commonalities instead of differences. Viewing an elderly person as a fellow human is thus considered to be a caring act that promotes and preserves his or her dignity. By analogy, meeting peer volunteers, that is, meeting similarly aged people, sometimes in similar situations - can serve as a way to increase older adults' self-respect, competence and sense of belonging to a community, all of which support their sense of dignity. In that context, the key finding of our study is that volunteerism, which seems to be preserved in shareholding network for the care of older people in rural Thailand, holistically promotes as well as satisfies the needs of older individuals in the process of strengthening their self-care.

Limitations

In our study, we conducted deductive content analysis to interpret older adults' experiences with participating in a shareholding network for the care of older people in rural areas. The results of the analysis were reviewed independently by all authors, which added rigor to the study. Nevertheless, according to Ricoeur (1976), ways of interpreting texts are multiple, and the interpretation that we have presented herein is the one that we found to be most likely. Interviews with participants followed a narrative approach, and during them, participants talked freely about their experiences and encounters with fellow members of the shareholding networks. In forming the sample, defining an adequate sample size, however, was challenging, as is common in qualitative research. Referring to Malterud et al., (2015), we nevertheless consider the "information power" in our study to be reasonably strong in relation to the aim of the study, the specificity of the sample, the use of established theory, the quality of the dialogues and the strategy of the analysis (Malterud, Siersma, & Guassora, 2015). Because the qualitative study took place in a single sub-district in only one province of Thailand with a limited number of participants, it is difficult to generalise the findings beyond the local context, although they may transferable to similar situations and encounters. Last, formulating the findings of research involves expressing oneself in a manner that touches the reader (Pusa, Hagglund, Nilsson, & Sundin, 2014). According to Ricoeur (1976), the reliability of the study thus lies in the recognition of others. In turn, knowledge gained from the study may be used as a basis to clarify experiences with participation in shareholding network and to raise awareness about the care of older adults in rural areas.

Conflict of interest and funding

The authors declare that there is no conflict of interest.

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